does not make sense. Right now I can't think of a piece of equipment that an ambulatory surgery center would have that would not be in a typical hospital operating room.

Q (By Mr. Kraeuter) Well, you are aware that some, for instance, MRI machines are better than others. Some are newer; some provide a clear, better photo or image, correct?

MS. RICHARDSON: Object to the form.

THE WITNESS: That's -- I have heard that said. Yes.

Q (By Mr. Kraeuter) And they cost more for better equipment.

MS. RICHARDSON: Object to the form.

THE WITNESS: I don't --

Q (By Mr. Kraeuter) Correct?

A I don't know. I don't have any idea on costs for MRI machines.

Q You have not looked at the overhead or cost basis approach to determine reasonableness of medical bills and fees; is that correct?

A Not in many years.

Q Okay. And, in fact, you don't have any data or information on the overhead or cost basis for the physicians and surgery center involved in this

case to provide its care, do you?

A No. But we do have that data for hospitals.

Q You're saying that you have the specific overhead costs for hospitals in the Savannah, Georgia area for this particular procedure?

A For all procedures.

Q Okay. I'm talking about for this particular procedure.

A Well, costs are kind of like cash. It's fungible. You know, how much --

Q Well --

A -- how much is the allocated cost for the procedure X, how much of the medical record department costs should they be responsible for. I mean, it's not, it's not like it's a specific piece of equipment. But we do have --

Q Well --

A We do have total cost, total charge, total collections and, and have access to specific departmental costs and charges for the, the major hospitals in the Savannah area.

Q And where, where is that data, sir?

A We get it from the Medicare cost report.

Q And that's a document that you've provided

to me today?

A No. I've not obtained it yet, but I have access to it. And for $90 I can get it for any hospital.

Q Is that a document that you relied on in forming your opinion in this case, or opinions in this case?

A No.

Q So as you sit here today, you don't know what the overhead cost is for any of the three Savannah hospitals for this type of spinal cord stimulator procedure?

A I don't think so. Let me just check and be sure that's not already pulled.

No. That information has not been pulled yet.

MR. KRAEUTER: Okay. All right. Let me take a minute, Lisa. I think I'm almost there.

MS. RICHARDSON: Okay.

(Whereupon, a brief recess was taken.)

Q (By Mr. Kraeuter) Now, Mr. Blount, is it true that the Medicare and Medicaid system has established a system for hospitals or doctors to be paid more than the DRG amount in an exceptionally high cost case?

A Yes. Medicare provides for outlier

payments in cases where there are significantly higher charges for a given case.

Q And when would that come into play? Is there a criteria?

A Yes. It is a very long and complex formula, but it is -- it can be determined.

Q Okay. And how often is that used?

A I would say the outliers overall would occur in less than 5 percent of all Medicare cases. And I think it may be even less than 3 percent.

Q You used the word "outliers." Does that have a significance?

A Yes. That's the general term referred to the additional payment that Medicare makes for certain cases above the standard DRG rate. It's called an outlier payment.

Q Do you know what the formula is for an outlier case?

A No, but I've seen it. It's about six lines long, single-space typed.

Q So I'm clear on your methodology: On the spinal cord stimulator issue, you relied on what databases for information?

A For the device, or the professional fee?

Q Let's --

A Or for --

Q -- talk about the device first.

A Well, when I say -- I should have said "facility." Facility or professional fee?

Q Facility.

A Okay. We relied on the U.S. Department of Veterans Affairs outpatient facility reasonable charge data for 2016. We also -- I also relied upon the average charges to Medicare patients reported by CMS for the hospitals in Georgia for DRG 29, and the average charge reported by Medical University of South Carolina for DRG 520 and 29, I believe. Yes. So those are the -- I think those are the sources of data that I've relied upon to evaluate the reasonableness of the facility component.

Now, to the extent --

Q Okay.

A -- the facility is included with the total charge, then I would also include in my sources the published peer-review studies that we talked about.

Q And what do you mean "the facility is included in the total"? What does that mean?

A Well, the, the peer-review studies that we talked about and that I used in -- researched in developing this report generally refer to an

aggregate cost amount which includes both professional fee and facility fee.

Q Let me ask you this, Mr. Blount: Do any of those peer-reviewed articles that we looked at -- that would be Exhibit 81, Exhibit 82, Exhibit 83, and Exhibit 84 -- do any of them express an opinion on the reasonableness of the charges --

A No.

Q -- contained in the various articles?

A No. They --

Q Okay.

A They disclose the charges and/or cost of the information that they researched.

Q Okay. All right. So we've talked about all of the information you used to formulate your opinion on the facility charge for the spinal cord stimulator; is that correct?

A I believe so.

Q All right. And we've established that you don't have a quibble or an opinion on the professional fees for the spinal cord stimulator; is that correct?

A Correct.

Q Okay. And is it my understanding that in determining in your opinion the reasonableness of the

ganglion block charges you looked at the PMIC and the Physicians' Fee Reference book; is that correct?

A Correct.

Q Anything else on the ganglion blocks?

A No.

Q Okay. And then for the Oxycodone -- no. Excuse me -- for the Gabapentin and the Nucynta -- I guess for Gabapentin you looked at the GoodRX website?

A Yes. As well as for --

Q Anything else? I'm sorry.

A No. That's the only source that I used for Gabapentin and Nucynta; same thing for Venlafaxine and Oxycodone.

Q Did you find a problem with the price of the Venlafaxine?

A Let's see. The charges in the doctor's projection was $30 for a 30-pill dose at 75 milligrams. I found charges at GoodRX to range from 10.50 to $15.19.

Q So do you have a problem with the rate or the cost of Venlafaxine in this case?

A Well, it's, it's about twice what it really is available for.

Q All right. Where did you put that in your

report?

A That's not in the written report, but it is in the Excel file called Orr Projected Medical Cost Analysis.

Q Is there anything else in the Excel document that's not in your written report?

A I'm not sure. Oxycodone, it's not so much the price. And I can't remember if I mentioned this in the written report or not, but basically Dr. Niederwanger, he didn't prescribe it. So I'm not sure --

Q Okay.

A -- that it really should be included in the projection at all.

Q If I look at page 8 of your report under findings --

A Okay.

Q -- is it, is it fair to say that those are your ultimate opinions in this case?

A Those -- well, the opinions are really on the opinion section. Let's see.

Okay. Yes. That -- you're correct. Starting at the top of page 8 of 10, findings.

Q Okay.

A Those are the -- those are -- contain my

major opinions.

Q Your non-major opinions would be between page 6 and page 7, analysis of facts, findings, and opinions?

A No. Those are really not opinions. The other opinions that we've -- that you have asked me about during this deposition that are not in the report, I would say those are not major opinions cause they're not in the written report.

Q I understand.

Okay. All right. I think that's all I have. Thank you, sir.

MS. RICHARDSON: Thank you.

MR. KRAEUTER: Thank you, Lisa.

THE REPORTER: Did you want this transcribed?

MR. KRAEUTER: Yes, please.

THE REPORTER: What would you like for your copy?

MR. KRAEUTER: Dennis McKee will get ahold of you-all to organize that. He handles all that for me.

THE REPORTER: Okay. Thanks.

(Deposition concluded at 1:18 p.m.)

E R R A T A P A G E

Pursuant to Rule 30(e) of the Federal Rules of Civil Procedure and/or Georgia Code Annotated 9-11-30(e), any changes in form or substance which you desire to make to your deposition testimony shall be entered upon the deposition with a statement of the reasons given for making them.

To assist you in making any such corrections, please use the form below. If supplemental or additional pages are necessary, please furnish same and attach them to this errata sheet.

I, the undersigned, L. LAMAR BLOUNT, CPA/CFF, FHFMA, do hereby certify that I have read the foregoing deposition and that to the best of my knowledge, said deposition is true and accurate (with the exceptions of the following corrections below).

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L. LAMAR BLOUNT, CPA/CFF, FHFMA

Sworn to and subscribed before me

_____,

Notary Public, this _____ day of

_____, 2016.

My commission expires: _____

C E R T I F I C A T E

STATE OF GEORGIA:

COUNTY OF DEKALB:

I hereby certify that the foregoing transcript was taken down as stated in the caption, that the witness was first duly sworn, and the questions and answers thereto were reduced to typewriting under my direction; that the foregoing pages 1 through 153 represent a true, correct, and complete transcript of the evidence given upon said hearing, and I further certify that I am not of kin or counsel to the parties in the case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case. The witness did reserve the right to read and sign the transcript.

This, the 22nd day of September, 2016.

LOUISE NIELSON, CCR-B-2121

Certified Court Reporter

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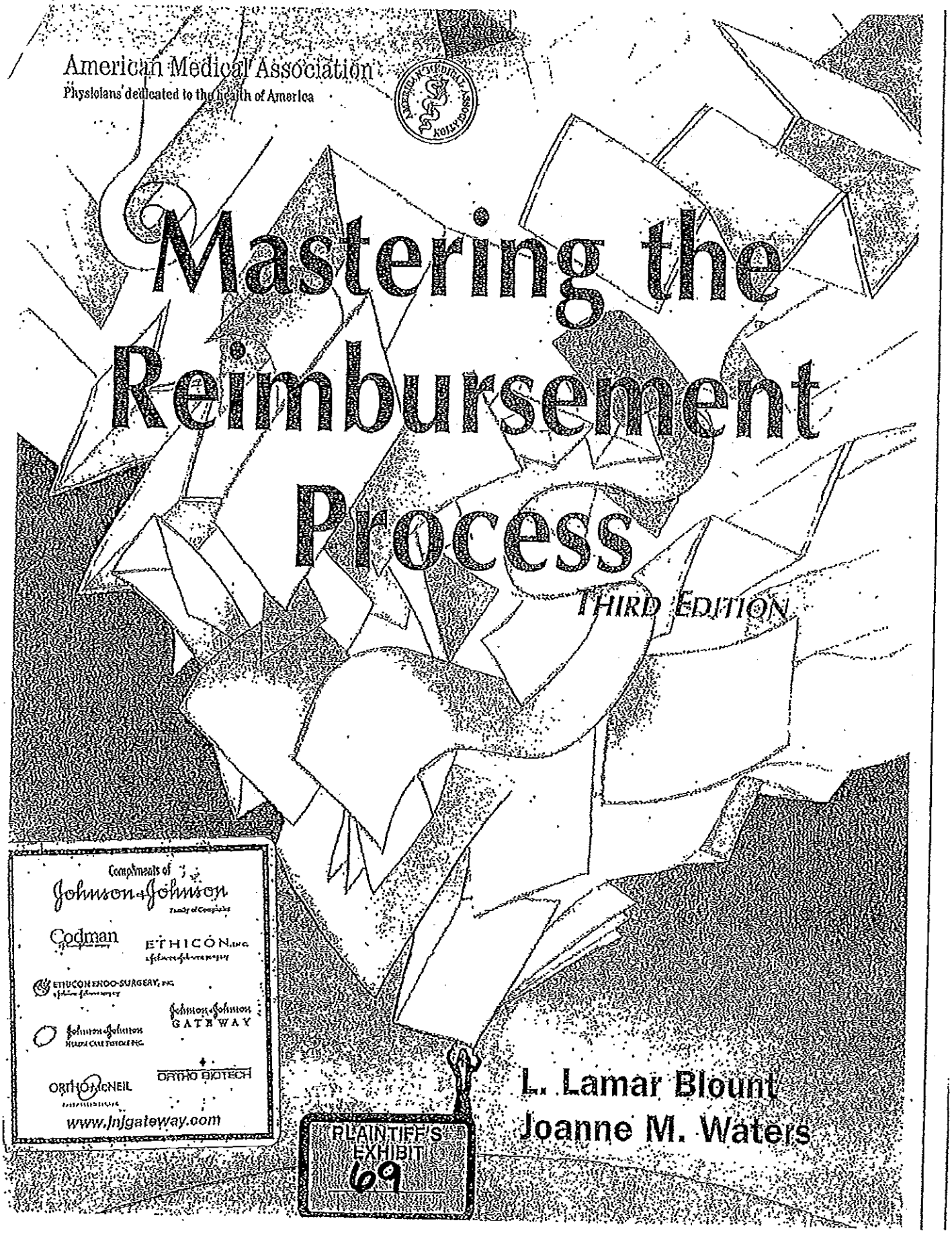
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Mastering

the Reimbursement Process

Third Edition

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Methods of Insurance Reimbursement

Payments to physicians and other providers differ depending on whether the patient has insurance and, if so, the type and extent of coverage. Most commonly, the provider bills a standard fee to the patient and/or files a claim to the patient's insurance carrier. With the advent of managed care, payments may be determined by a contracted discount rate, a fee schedule, a case rate, or a capitated rate. For example, Medicare payments are determined on the basis of a national fee schedule. Each of these payment methods is discussed below. The traditional indemnity health plan is based on predefined payment allowances that may vary by provider specialty and/or geographic location. Data may be generated from within the plan's own records or obtained from outside.

Fee Schedules

The Usual, Customary, and Reasonable (UCR) Method

Historically, commercial and Blue Shield plans have based provider payments on the lowest of the following:

- The provider's most frequent charge for the service (usual).
- The average charge by providers in the area (customary).
- The actual charge appearing on the claim for the service (reasonable).

This method of determining payment is called the usual, customary, and reasonable method, or UCR. Each component amount is calculated on the basis of previous charges submitted to the insurer. For individual providers, a profile of all charges submitted is maintained, and the most frequent charge is identified to determine the usual charge. All charges of providers within a specified area are collated and averaged to determine a customary charge. To arrive at a payment amount for a claim, the carrier then compares the physician's most frequent charge (the usual), the average charge of all providers in the area (the customary), and the actual charge submitted on the claim (which, if submitted by a provider, must be reasonable to that provider). Whichever amount is the lowest is used as the basis for payment (the allowable charge).

For example, a physician usually charges $100 for a procedure and the average charge of providers in the geographic area is $105. The physician submits a charge of $120 on a particular claim. For that claim, payment will be based on $100, which is the lowest of the usual ($100), customary ($105), and actual ($120) charges.

Health Law Network

Lamar Blount, CPA/CFF, FHFMA

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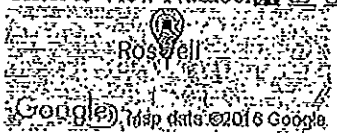

About the Expert

HLN consults in civil and criminal cases involving: UCR, reasonable charges & reimbursement; forensic audits; provider & payor disputes; medical record & billing documentation; ICD & CPT coding; compliance programs; business damages; Medicare, Medicaid and Insurance fraud; and antitrust. MD, RN, RHIA, CPC, CFE, ChFC, MHA and CPA experts available.

Areas of Expertise

- Healthcare Practices and Records
- Medical / Medicare / Medicaid Fraud
- Medical Billing, Coding and Insurance

Expert's Profile

HLN's founder is the co-author of the American Medical Association's best selling Mastering the Reimbursement Process book. During 30+ years serving the healthcare industry, Lamar Blount has provided consulting services for more than 300 clients in 30 states.

Prior to founding Health Law Network, Lamar was founder and chairman of Healthcare Management Advisors (HMA) from 1990 to 2002, providing compliance, reimbursement, clinical data and financial expertise to over 1,000 healthcare organizations nationwide, and he was previously a manager with a Big 4 international CPA firm.

Lamar is a nationally recognized author and is a Fellow and Certified Healthcare Financial Professional in the Healthcare Financial Management Association, a member of the American Institute of CPAs and Georgia Society of CPAs, and has served as an Arbitrator for American Health Lawyers Association. Lamar has been admitted as an expert in multiple US District and State Courts and Administrative Hearings, and he is Certified in Financial Forensics by the AICPA.

Health Law Network's expertise includes: Accounting, APCs, Business Damages, Contractual Disputes, Cost Reports, DRGs, ERISA, False Claims, Fraud, HIPAA, ICD & CPT Coding, Insurance, Rate Setting, Self Disclosure and Valuations.

Representative Engagements

+ Developed self disclosure process for 12-hospital group, audited over 1,000 Medicare claims, and statistically projected the overpayment settlement.

+ Assisted law firm representing one of the largest national home health chains to amend over 200 cost reports and recover over $2 million in additional reimbursement.

+ Provided litigation support to law firm defending physician against Medicare fraud charges, including testimony in US District Court.

+ Calculated economic damages and served as advisor to law firm defending a national hospital chain against allegations of lost profits resulting from a failed sale of multiple hospitals.

+ Developed strategic business recommendations for $30 million specialty MD practice to establish succession plan, implement compensation plan and reduce risks.

+ Engaged by a state Medical Board of Examiners to evaluate the reasonableness of charges for a physician's claims.

+ Developed proforma detailed hospital and physician bill totaling over $1 million for an attorney representing a burn victim treated by a hospital that does not charge for its services.

+ Evaluated potential unbundling of IV charges and proper cost report treatment of Observation Beds by multiple hospitals for an HMO.

+ Forensic audit of labor cost and fringe benefits for a $9 million contracted service dispute between two governmental entities.

+ Evaluation and report on usual, customary and reasonable (UCR) medical and prescription charges over 10 years for 20 personal injury plaintiffs involving over 150,000 pages of billing and medical record documents.

+ Developed statistical sampling plan to evaluate over 60,000 Medicare claims in a False Claims Act case within a tight court deadline.

Legal references are available upon request.

Personal Achievements

Publications

- Mastering the Reimbursement Process - AMA book

Prior assignments

- • Developed Medicare OIG self disclosure process for 12-hospital group
- • Amended over 200 cost reports and recover over $2 million in additional reimbursement for national chain
- • Expert testimony defending physician against criminal Medicare fraud charges
- • Litigation support defending a national hospital chain against allegations of lost profits
- • Served as NHLA Arbitrator in dipute between hospital and HMO
- • Organized and coordinated multi-hospital group reimbursment appeals
- • Assisted state Attorney General's office investigation of Home Health fraud

Percentage of time spent as expert

- 25%

Number of expert assignments / year

- 12

Attorney Endorsed sm

Courtroom & Deposition Demeanor (1)

- Rick Mullins - McAfee Taft

Knowledge in Area of Expertise (1)

- Rick Mullins - McAfee Taft

Pleasure to Work With (1)

- Rick Mullins - McAfee Taft

Problem Solving - Anticipates Issues / Suggests Solutions (1)

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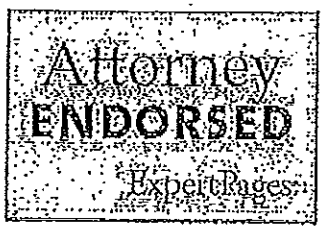

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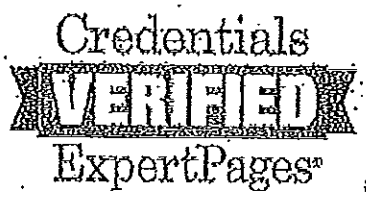

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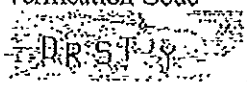

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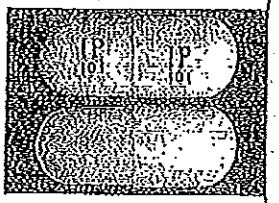

Gabapentin Generic Neurontin

Gabapentin (Neurontin) is an inexpensive drug used to control partial seizures in adults with epilepsy. It is also used to treat certain types of nerve pain. This drug is more popular than comparable drugs. It is available in generic and brand versions. Generic gabapentin is covered by most Medicare and insurance plans, but some pharmacy coupons or cash prices may be lower. Compare anti-epileptics.

Prescription Settings	generic	capsule	100mg	30 capsules

SELECT DOSAGE
- 100mg
- 300mg
- 400mg

Prices and coupons for 30 capsules of gaba

Set your location for drug prices near you

Sams Club		$5.68 with free discount	GET FREE DISCOUNT
HealthWarehouse		$6.90 purchase online	BUY ONLINE
Walmart		$7.28 with free discount	GET FREE DISCOUNT
Kroger Pharmacy	$9 est cash price	$8.60 with free coupon	GET FREE COUPON
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SPINAL CORD STIMULATION FOR CHRONIC PAIN-TRUNK AND/OR LIMBS COMMONLY BILLED CODES EFFECTIVE JANUARY 2016

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FOR QUESTIONS PLEASE CONTACT US AT NEURO.US.REIMBURSEMENT@MEDTRONIC.COM

ICD-10-CM[1] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Pain codes from the G89 series are used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying condition. Neurostimulation Therapy is directed at managing chronic, intractable pain rather than treating the underlying disorder. When a patient is admitted for insertion of a neurostimulator for pain control, the pain code is sequenced as the principal diagnosis. Additional codes may then be assigned to identify the underlying cause as well to give more detail about the nature and location of the pain. Note that when the encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is also inserted for pain control, the underlying disorder is assigned as the principal diagnosis. However, an encounter specifically to insert a neurostimulator is most common.

Chronic Pain Disorders	G89.0	Central pain syndrome
	G89.29	Other chronic pain
	G89.4	Chronic pain syndrome
	Note: Pain must be specifically documented as "chronic" to use code G89.29. Similarly, the diagnostic term "chronic pain syndrome" must be specifically documented to assign code G89.4. If not documented, then symptom codes for pain may be assigned although they cannot be sequenced as principal diagnosis. Rather, the underlying condition would ordinarily be used as the principal diagnosis in this circumstance.	
Reflex Sympathetic Dystrophy (Complex Regional Pain Syndrome I) and Causalgia (Complex Regional Pain Syndrome II)	G90.511	Complex regional pain syndrome I of right upper limb
	G90.512	Complex regional pain syndrome I of left upper limb
	G90.513	Complex regional pain syndrome I of upper limb, bilateral
	G90.519	Complex regional pain syndrome I of unspecified upper limb
	G90.521	Complex regional pain syndrome I of right lower limb
	G90.522	Complex regional pain syndrome I of left lower limb
	G90.523	Complex regional pain syndrome I of lower limb, bilateral
	G90.529	Complex regional pain syndrome I of unspecified lower limb
	G56.40	Causalgia of unspecified upper limb
	G56.41	Causalgia of right upper limb
	G56.42	Causalgia of left upper limb
	G57.70	Causalgia of unspecified lower limb
	G57.71	Causalgia of right lower limb
	G57.72	Causalgia of left lower limb
	Note: Codes from the G89 series should not be assigned with causalgia or reflex sympathetic dystrophy because pain is an integral component of these disorders.	

CONTINUED

SPINAL CORD STIMULATION COMMONLY BILLED CODES

ICD-10-CM[1] Diagnosis Codes continued

Arachnoiditis	G03.1	Chronic meningitis
	G03.9	Meningitis, unspecified
Peripheral Neuropathy	G56.90	Unspecified mononeuropathy of unspecified upper limb
	G56.91	Unspecified mononeuropathy of right upper limb
	G56.92	Unspecified mononeuropathy of left upper limb
	G57.90	Unspecified mononeuropathy of unspecified lower limb
	G57.91	Unspecified mononeuropathy of right lower limb
	G57.92	Unspecified mononeuropathy of left lower limb
Epidural Fibrosis	G96.12	Meningeal adhesions, spinal, cerebral
Radiculopathy	M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
	M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
	M54.12	Radiculopathy, cervical region
	M54.13	Radiculopathy, cervicothoracic region
	M54.14	Radiculopathy, thoracic region
	M54.15	Radiculopathy, thoracolumbar region
	M54.16	Radiculopathy, lumbar region
	M54.17	Radiculopathy, lumbosacral region
Postlaminectomy Syndrome	M96.1	Postlaminectomy syndrome, not elsewhere classified
Attention to Device	Z45.42[2]	Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord)

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2015. Accessed November 30, 2015.
2. Code Z45.42 is used as the principal diagnosis when patients are seen for routine device maintenance, such as periodic device checks and programming, as well as routine device replacement. A secondary diagnosis code is then used for the underlying condition.

ICD-10-PCS[1] Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Lead Insertion[2,3]	00HU0MZ	Insertion of neurostimulator lead into spinal canal, open approach
	00HU3MZ	Insertion of neurostimulator lead into spinal canal, percutaneous approach
	00HV0MZ	Insertion of neurostimulator lead into spinal cord, open approach
	00HV3MZ	Insertion of neurostimulator lead into spinal cord, percutaneous approach
Lead Removal[2,4]	00PU0MZ	Removal of neurostimulator lead from spinal canal, open approach
	00PU3MZ	Removal of neurostimulator lead from spinal canal, percutaneous approach
	00PV0MZ	Removal of neurostimulator lead from spinal cord, open approach
	00PV3MZ	Removal of neurostimulator lead from spinal cord, percutaneous approach
Lead Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[5]	
Lead Revision[2,6]	00WU0MZ	Revision of neurostimulator lead in spinal canal, open approach
	00WU3MZ	Revision of neurostimulator lead in spinal canal, percutaneous approach
	00WV0MZ	Revision of neurostimulator lead in spinal cord, open approach
	00WV3MZ	Revision of neurostimulator lead in spinal cord, percutaneous approach

CONTINUED ON NEXT PAGE

ICD-10-PCS[1] Procedure Codes continued

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Generator Implant[7,8]	0JH70BZ	Insertion of single array stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80BZ	Insertion of single array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
	0JH70DZ	Insertion of multiple array stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80DZ	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
	0JH70EZ	Insertion of multiple array rechargeable stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80EZ	Insertion of multiple array rechargeable stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Generator Removal[8]	0JPT0MZ	Removal of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach
Generator Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[5]	
Generator Revision[9,10]	0JWT0MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html. Updated October 1, 2015. Accessed November 30, 2015.
2. ICD-10 coding guidelines have not yet addressed which body part, U-Spinal Canal or V-Spinal Cord, better describes the location of spinal leads. Therefore, both options are displayed. Note, however, that Medtronic spinal neurostimulation leads are intended to be inserted into the epidural space of the spine, which is coded to U-Spinal Canal according to the ICD-10-PCS Body Part Key.
3. Approach value 0-Open is used when leads are placed via laminectomy. Approach value 3-Percutaneous is used when leads are placed by spinal needle via puncture or minor incision.
4. Approach value 0-Open is used when leads are removed via laminectomy or other direct surgical exposure of the spinal canal. Approach value 3-Percutaneous is used when leads are removed by puncture or minor incision. Only the ICD-10-PCS codes for surgical removal are displayed. Approach value X-External is also available for removal of leads by simple pull.
5. CMS ICD-10-PCS Reference Manual 2016, p.67.
6. For Lead Revision, the ICD-10-PCS codes refer to surgical revision of leads within the spinal canal, eg, repositioning. For revision of the subcutaneous portion of the lead or revision of a subcutaneous extension, see Generator Revision.
7. Codes defined as 'multiple array' include dual array neurostimulator pulse generators, a type of multiple array generator in which two leads are connected to one generator. It refls a single-array non-rechargeable generator and PrimeAdvanced is a dual-array non-rechargeable generator. RestoreAdvanced, RestoreSensor, and RestoreUltra are dual-array rechargeable generators (see the ICD-10-PCS Device Index). Do not assign default device value H-Stimulator Generator.
8. Placement of a neurostimulator generator is shown with the approach value 0-Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free the device.
9. The ICD-10-PCS codes shown can be assigned for opening the pocket for generator revision, as well as reshaping or relocating the pocket with reinserting the same generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead or an extension. Because these services usually involve removing and reinserting the same generator as well, they can also be represented by the ICD-10-PCS generator revision codes.
10. Approach value X-External is also available for external generator manipulation without opening the pocket, eg, to correct a flipped generator.

SPINAL CORD STIMULATION COMMONLY BILLED CODES

HCPCS II Device Codes[1]

These codes are utilized by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. For implantable devices, that is generally the facility. It may also be the physician, most commonly for trial leads placed in the office. For specific Medicare hospital outpatient instructions for medical devices, see the Device C-Codes for Medicare.

Lead[2]	L8680	Implantable neurostimulator electrode, each
Pulse Generator[3]	L8679	Implantable neurostimulator pulse generator, any type
	L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
External Recharger	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Patient Programmer	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

1. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services. Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System (HCPCS) Level II. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. Accessed November 30, 2015.
2. Physicians should *not* submit code L8680 to Medicare for leads placed in the office. This code is not separately billable to Medicare because the cost of the lead is already valued in the CPT procedure code. Centers for Medicare and Medicaid Services. MLN Matters Number MM8645. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf. Accessed November 30, 2015. Code L8680 remains available for use with non-Medicare payers, though physicians should check with the payer for specific coding and billing instructions. Likewise, hospitals and ASCs may be able to submit L8680 for non-Medicare payers but should check with the payer for instructions.
3. Effective January 2014, generator codes L8685-L8688 are not payable by Medicare. Specifically for billing Medicare, code L8679 is available for physician use, while hospitals typically use C-codes and ASCs generally do not submit HCPCS II codes for devices. For non-Medicare payers, codes L8685-L8688 remain available. However, all providers should check with the payer for specific coding and billing instructions.

Device C-Codes[1] (Medicare)

Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. Unlike regular HCPCS II device codes, the extension is separately codable using C-codes.

ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[2]

Pulse Generator (non-rechargeable)	C1767	Generator, neurostimulator (implantable) non-rechargeable
Pulse Generator (rechargeable)	C1820	Generator, neurostimulator (implantable), non-high frequency with rechargeable battery and charging system
Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Leads	C1778	Lead, neurostimulator (implantable)
	C1897	Lead, neurostimulator, test kit (implantable)
Patient Programmer	C1787	Patient programmer, neurostimulator

1. Device C-codes are HCPCS Level II codes and also maintained by the Centers for Medicare and Medicaid Services. (Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html. Accessed November 30, 2015)
2. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. For example, the ASC should report its charge for the generator. However, because the generator is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the generator and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. See the Medicare Claims Processing Manual, Chapter 14, Section 40: Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 30, 2015. See also MLN Matters SE0742 p.9-10: Centers for Medicare and Medicaid Services. MLN Matters Number SE0742 Revised. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0742.pdf. Accessed November 30, 2015.

Device Edits (Medicare)[1]

Medicare's procedure-to-device edits require that when certain CPT® procedure codes for device implantation are submitted on a hospital outpatient bill, HCPCS II codes for devices must also be billed. Effective January 2015, the edits are broadly defined and may include any HCPCS II device code with any CPT procedure code used in earlier versions of the edits.[2] Within this context, the HCPCS II device codes shown below are appropriate for the CPT procedure codes and will pass the edits.

CPT Procedure Code	CPT Code Description[3]	HCPCS II Device Codes	HCPCS II Code Description
63650[4]	Percutaneous implantation of neurostimulator electrode array, epidural	C1778	Lead, neurostimulator (implantable)
		C1897	Lead, neurostimulator, test kit (implantable)
63655[4,5]	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	C1778	Lead, neurostimulator (implantable)
63685[6]	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	C1767	Generator, neurostimulator (implantable), non-rechargeable
		C1820	Generator, neurostimulator (implantable), non-high frequency with rechargeable battery and charging system

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems. Final Rule. 80 Fed. Reg. 70421-70422. http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. Published November 13, 2015. Accessed November 30, 2015.
2. Centers for Medicare & Medicaid Services. Device and Procedure Edits. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/device_procedure_archive.html. Last updated April 10, 2013. Accessed November 30, 2015.
3. CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
4. HCPCS II code L8690 will also pass the edits with CPT procedure codes 63650 and 63655, but this code is not shown because it is not otherwise recognized by Medicare.
5. HCPCS II device code C1897 will pass the edits with CPT procedure code 63655. In practice, however, HCPCS device code C1897 is not appropriate with CPT procedure code 63655 because this type of kit is not currently used when testing is performed via laminectomy.
6. HCPCS II device codes L8686-L8688 will also pass the edits with CPT procedure code 63685, but these codes are not shown because they are not otherwise recognized by Medicare. HCPCS II device code L8679 does not satisfy the edits.

SPINAL CORD STIMULATION: COMMONLY BILLED CODES

Physician Coding and Payment — January 1, 2016 – December 31, 2016

CPT® Procedure Codes

Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description[1]	Medicare RVUs[2]		Medicare National Average[3]	
		For physician services provided in:[4]			
		Physician Office[5]	Facility	Physician Office[5]	Facility
Screening Test[6,7,8]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[9,10]	38.25	12.00	$1,370	$430
Lead Implantation[6,7,8]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[9,10]	38.25	12.00	$1,370	$430
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	N/A	24.00	N/A	$860
Generator Implantation or Replacement[7,11]	63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	N/A	10.64	N/A	$381
Removal of Leads[7,12,13,14]	63661 Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	16.64	9.30	$596	$333
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	N/A	24.34	N/A	$872
Revision or Replacement of Leads[7,13,14]	63663 Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	22.84	13.17	$818	$472
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	N/A	25.02	N/A	$896
Revision or Removal of Generator[7,11]	63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver	N/A	10.70	N/A	$383

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Physician Coding and Payment continued

Procedure	CPT Code and Description[1]	Medicare RVUs[2]		Medicare National Average[3]	
		For physician services provided in:[4]			
		Physician Office[5]	Facility	Physician Office[5]	Facility
Analysis/ Programming Note: In the office, analysis and programming may be furnished by a physician, practitioner with an "incident to" benefit, or auxiliary personnel under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. The patient or payer should not be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.	**95970** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming.	1.93	0.69	$69	$25
	95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple spinal cord or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/ transmitter, with intraoperative or subsequent programming[15]	1.42	1.16	$51	$42
	95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); complex spinal cord or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming[15]	1.66	1.19	$59	$43

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Physician Coding and Payment

1. CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare & Medicaid Services. Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Final Rule; 80 Fed. Reg. 70885-71386. http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-26005.pdf. Published November 16, 2015. Accessed November 30, 2015. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
3. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2016 is $35.8279 through December 31, 2016 per 80 Fed. Reg. 71357. http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-26005.pdf. Published November 16, 2015. Accessed November 30, 2015. See also the January 2016 release of the PFS Relative Value Files RVU16A at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. Published November 13, 2015. Accessed November 30, 2015. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are excluded in the payment amount shown.
4. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
5. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g., in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate. Centers for Medicare & Medicaid Services. Details for Title: CMS-1631-FC. CY 2016 PFS Final RVUs Addenda, Addendum A: Explanation of Addendum B and C. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending. Updated November 5, 2015. Accessed November 30, 2015.
6. As defined and as published by the AMA (CPT Assistant, June 1998, p.4), these codes represent a single lead. When more than one lead is placed, each is coded separately. However, Medicare does not permit the use of bilateral modifier –50 or –LT/–RT on these codes. Some payors recognize that each code represents a distinct lead when modifier –51 or modifier –59 is appended to the additional codes. Note that Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed.
7. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package. The services are not separately coded, billed or paid when rendered by the physician who performed the surgery. These services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 or 90 days depending on the specific procedure, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal.
8. The published vignettes for codes 63650 and 63655 include fluoroscopy and, according to guidelines published by the American Association of Neurological Surgeons (AANS Guide to Coding, 2012 Edition, p.66), its use is inherent to lead implantation and should not be coded separately. In addition, National Correct Coding Initiative (NCCI) edits prohibit coding fluoroscopy separately with 63650 and 63655.
9. The Physician Office RVUs for code 63650 are valued to include payment for the lead and other practice expenses associated with office-based lead insertion, eg, kits. HCPCS code L8680 should not be reported separately for the lead in conjunction with office-based lead insertion.
10. The AMA has published (CPT Assistant, October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650.
11. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI policy does not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new generator. When the same generator is removed and then re-inserted, the "revision" code is used.
12. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (CPT Assistant, August 2010, p.8, 15; April 2011, p.10-11, 15).
13. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately (CPT Assistant, August 2010, p.8, 15; April 2011, p.10-11, 15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
14. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661 (CPT Assistant, April 2011, p.11, 15). NCCI edits allow this combination without use of a modifier.
15. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters. The parameters that qualify are: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time (stimulation parameters changing in time periods of minutes including dose lockout times), more than one clinical feature.

SPINAL CORD STIMULATION COMMONLY BILLED CODES

Hospital Outpatient Coding and Payment — Effective January 1, 2016 – December 31, 2016

CPT® Procedure Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of approximately 700 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC.

For 2016, there are 35 APCs which are designated as Comprehensive APCs (C-APCs). Each CPT procedure code assigned to one of these C-APCs is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service.

When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. However, there are no complexity adjustments for spinal cord stimulation therapy for chronic pain.

As shown on the tables below, neurostimulation therapy for chronic pain is subject to C-APCs specifically for implantation and revision/replacement of the leads, and insertion/replacement of the generator. C-APCs are identified by status indicator J1.

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Screening Test[5,6]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[7]	5462	Level 2 Neurostimulator and Related Procedures	J1	71.1342	$5,244
Lead Implantation[5,6,8]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[7]	5462	Level 2 Neurostimulator and Related Procedures	J1	71.1342	$5,244
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	5463	Level 3 Neurostimulator and Related Procedures	J1	235.4611	$17,359
Generator Implantation or Replacement[9,10]	63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5464	Level 4 Neurostimulator and Related Procedures	J1	362.5417	$26,728
Removal of Leads[11,12,13]	63661 Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	5431	Level 1 Nerve Procedures	Q2	18.8886	$1,393
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5461	Level 1 Neurostimulator and Related Procedures	Q2	29.6866	$2,189

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Hospital Outpatient Coding and Payment continued

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Revision or Replacement of Leads[12,13]	63663 Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	5462	Level 2 Neurostimulator and Related Procedures	J1	71.1342	$5,244
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5462	Level 2 Neurostimulator and Related Procedures	J1	71.1342	$5,244
Revision or Removal of Generator[9]	63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver	5461	Level 1 Neurostimulator and Related Procedures	Q2	29.6866	$2,189
Analysis and Programming Note: In the hospital, analysis and programming may be furnished by a physician or other practitioner, with or without support from a manufacturer's representative. Neither the payer or patient should be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.	95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuro-muscular) neurostimulator pulse generator/ transmitter, without reprogramming	5734	Level 4 Minor Procedures	Q1	1.2367	$91
	95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple spinal cord or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/ transmitter, with intraoperative or subsequent programming[14]	5742	Level 2 Electronic Analysis of Devices	S	1.4438	$106
	95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements), complex spinal cord or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming[14]	5742	Level 2 Electronic Analysis of Devices	S	1.4438	$106

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Hospital Outpatient Coding and Payment

1. CPT Copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare & Medicaid Services. *Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems. Final Rule.* 80 Fed. Reg. 70297-70507. http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. Published November 13, 2015. Accessed November 30, 2015.
3. Status indicator (SI) shows how a code is handled for payment purposes: N = packaged service, no separate payment; S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure; Q2 = T packaged codes, not paid separately when billed with a T procedure; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2016 is $73.725. The conversion factor of $73.725 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program. Centers for Medicare & Medicaid Services. *Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems. Final Rule.* 80 Fed. Reg. 70351-70357. http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. Published November 13, 2015. Accessed November 30, 2015. Payment is adjusted by the wage index for each hospital's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. As defined and as published by the AMA (*CPT Assistant*, June 1998, p.4), these codes represent a single lead, and when more than one lead is placed, each is coded separately. However, Medicare does not permit the use of bilateral modifier –50 or –LT/–RT on these codes. Some payers recognize that each code represents a distinct lead when modifier –59 is appended to the additional codes. Note that Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the NUE values may be appealed.
6. The published vignettes for codes 63650 and 63655 include fluoroscopy and, according to guidelines published by the American Association of Neurological Surgeons (AANS *Guide to Coding*, 2012 Edition, p.66), its use is inherent to lead implantation and should not be coded separately. In addition, National Correct Coding Initiative (NCCI) edits prohibit coding fluoroscopy separately with 63650 and 63655.
7. The AMA has published (*CPT Assistant*, October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650.
8. When implantation of two leads is coded and billed, ie. 63650 plus 63650-59 or 63655 plus 63655-59, the entire encounter continues to map to the APCs shown. Because these are C-APCs and no complexity adjustment applies, there is no additional payment for the second lead.
9. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI policy does not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new pulse generator. When the same pulse generator is removed and then re-inserted, the "revision" code is used.
10. When generator implantation is coded and billed together with lead implantation, for example 63685 plus 63650, the entire encounter continues to map to the APC for generator implantation. Because this is a C-APC and no complexity adjustment applies, there is no additional payment for the lead.
11. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (*CPT Assistant*, August 2010, p.8,15; April 2011 p.10-11,15).
12. The AMA has published that replacement codes 63663 and 63664 are to be assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately (*CPT Assistant*, August 2010, p.8,15; April 2011 p.10-11,15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
13. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661 (*CPT Assistant*, April 2011 p.11,15). NCCI edits allow this combination without use of a modifier.
14. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters. The parameters that qualify are: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time (stimulation parameters changing in time periods of minutes including dose lockout times), more than one clinical feature.

Hospital Inpatient Coding and Payment — Effective October 1, 2015 – September 30, 2016

MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 755 diagnosis-related groups, based on the ICD-10-CM codes assigned to the diagnoses and ICD-10-PCS codes assigned to the procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios. For neurostimulation therapy for chronic pain, DRG assignment varies depending on the diagnosis and the specific procedures performed.

Procedure	Scenario		MS-DRG[1]	MS-DRG Title[1,2]	Relative Weight[1]	Medicare National Average[3]
Implantation or Replacement: Whole System	Whole system implant or replacement generator plus leads	Pain disorder or due to causalgia or RSD, and other nervous system disorders[4]	028	Spinal Procedures W MCC	5.3695	$31,713
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.0548	$18,042
		Due to musculoskeletal disorders[5]	518	Back and Neck Procedures Except Spinal Fusion W MCC or Disc Device/Neurostimulator	2.9249	$17,275
Implantation or Replacement: Generator Only	Generator only implant or replacement	Pain disorder or due to causalgia or RSD, and other nervous system disorders[6]	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.8044	$22,469
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.1354	$12,612
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9242	$11,365
		Due to musculoskeletal disorders[7]	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	4.8532	$28,664
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	2.7416	$16,192
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/MCC	1.7615	$10,404

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Hospital Inpatient Coding and Payment continued

Procedure	Scenario		MS-DRG[1]	MS-DRG Title[1,2]	Relative Weight[1]	FY 2015 Medicare National Average[3]
Implantation or Replacement: Leads Only	Lead only implant or replacement	Pain disorder or due to causalgia or RSD, and other nervous system disorders[4]	028	Spinal Procedures W MCC	5.3695	$31,713
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.0548	$18,042
			030	Spinal Procedures W/O CC/MCC	1.7982	$10,620
		Due to musculoskeletal disorders[5]	518	Back and Neck Procedures Except Spinal Fusion W MCC or Disc Device /Neurostimulator	2.9249	$17,275
			519	Back and Neck Procedures Except Spinal Fusion W CC	1.6805	$9,925
			520	Back and Neck Procedures Except Spinal Fusion W/O CC/MCC	1.1812	$6,976
Removal (without replacement)[4,6]	Entire system removal, generator plus leads		028	Spinal Procedures W MCC	5.3695	$31,713
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.0548	$18,042
			030	Spinal Procedures W/O CC/MCC	1.7982	$10,620
	Generator only removal		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
	Lead only removal		028	Spinal Procedures W MCC	5.3695	$31,713
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.0548	$18,042
			030	Spinal Procedures W/O CC/MCC	1.7982	$10,620
Revision[4]	Lead revision[6]		028	Spinal Procedures W MCC	5.3695	$31,713
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.0548	$18,042
			030	Spinal Procedures W/O CC/MCC	1.7982	$10,620

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Hospital Inpatient Coding and Payment

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2016 Rates. Final Rule 80 Fed. Reg. 49325 - 49886. http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf. Published August 17, 2015. Accessed November 30, 2015.
2. WMCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.
3. Payment is based on the average standardized operating amount ($5,467.39) plus the capital standard amount ($438.75). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2016 Rates. Final Rule 80 Fed. Reg. 60055-60069. Tables 1A-1D. http://www.gpo.gov/fdsys/pkg/FR-2015-10-05/pdf/2015-25269.pdf. Published October 5, 2015. Accessed November 30, 2015. The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
4. There are three MS-DRGs for spinal procedures with a nervous system principal diagnosis (DRGs 028, 029, and 030): the difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both the leads and the generator are coded, MS-DRG 030 cannot be assigned. Instead, MS-DRG 029 is automatically assigned for a whole system implantation regardless of whether a CC is present or not. If an MCC is also present with a whole system implantation, MS-DRG 028 is assigned. For other spinal procedures, such as lead only implantation or lead removal, the full range of MS-DRGs 028, 029, and 030 is available.
5. There are three MS-DRGs for back and neck procedures with a musculoskeletal system principal diagnosis (DRGs 518, 519 and 520): the difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both the leads and the generator are coded, MS-DRG 518 is automatically assigned regardless of whether an MCC is present. For other spinal procedures, such as lead only implantation, the full range of MS-DRGs 518, 519 and 520 is available.
6. The ICD-10-PCS codes for generator implantation are not specific to spinal neurostimulation so the MS-DRGs for Other Nervous System Procedures are assigned.
7. The generator implantation codes are designated as nervous system procedures only. When a musculoskeletal disorder is used as the principle diagnosis, the "mismatch" DRGs of 981, 982, and 983 are assigned. The DRGs are valid and payable.
8. Device removal without replacement and revision procedures are typically performed as an outpatient. They are shown here for the occasional scenario where removal or revision take place as an inpatient. The DRGs reflect surgical revision of the intraspinal portion of the lead, eg, repositioning a displaced lead within the spinal canal.

SPINAL CORD STIMULATION COMMONLY BILLED CODES

ASC Coding and Payment — Effective January 1, 2016 – December 31, 2016

CPT® Procedure Codes

ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, Comprehensive APCs are used only for hospital outpatient services and are not applied to procedures performed in ASCs.

Each CPT code designated as a covered procedure in an ASC is assigned a comparable relative weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

Procedure	CPT Code and Description[1]	Payment Indicator[2,3,4]	Multiple Procedure Discounting[5]	Relative Weight[2,4]	Medicare National Average[2,4,6]
Screening Test[7]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[8]	J8	N	90.4068	$3,994
Lead Implantation[7]	63650 Percutaneous implantation of neurostimulator electrode array, epidural[8]	J8	N	90.4068	$3,994
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	J8	N	334.9553	$14,797
Generator Implantation or Replacement[9]	63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	J8	N	481.2133	$21,259
Removal of Leads[10,11,12]	63661 Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	G2	N	17.6268	$779
	63662 Removal of spinal neurostimulator electrode plate/paddle placed via laminotomy or laminectomy, including fluoroscopy when performed	G2	N	27.7035	$1,224
Revision or Replacement of Leads[11,12]	63663 Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	J8	N	90.4068	$3,994
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	J8	N	90.4068	$3,994
Revision or Removal Of Generator[9]	63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver	A2	N	27.7035	$1,224

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ASC Coding and Payment

1. CPT Copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems. Final Rule. 80 Fed. Reg. 70474-70502. http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. Published November 13, 2015. Accessed November 30, 2015.
3. The Payment Indicator shows how a code is handled for payment purposes. A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC; J8 = device-intensive procedure, payment amount adjusted to incorporate device cost.
4. Medicare national average payment is determined by multiplying the relative weight by the ASC conversion factor. The 2016 ASC conversion factor is $44.177. The conversion factor of $44.177 assumes the ASC meets quality reporting requirements. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems...Final Rule. 80 Fed. Reg. 70501. http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf. Published November 13, 2015. Accessed November 30, 2015. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the stated national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.
6. For Medicare billing, ASCs use a CMS-1500 form.
7. As defined and as published by the AMA (*CPT Assistant*, June 1998, p.4), these codes represent a single lead. When more than one lead is placed, each is coded separately. Medicare does not recognize the use of bilateral modifier –50 for payment in the ASC and instructs that bilateral procedures should be reported with the CPT procedure code reported on two separate lines, or reported on a single line with units of "2". Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual. Chapter 14—Ambulatory Surgery Centers. section 40.5 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Updated May 23, 2008. Accessed November 30, 2015. For billing bilateral leads to non-Medicare payers, contact the payer for instructions. Note that Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed.
8. The AMA has published (*CPT Assistant*, October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650.
9. When an existing generator is removed and replaced by a new generator, only the generator replacement code 61685 may be assigned. NCCI policy does not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new pulse generator. When the same pulse generator is removed and then re-inserted, the "revision" code is used.
10. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (*CPT Assistant*, August 2010, p.8,15; April 2011, p.10-11,15).
11. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately (*CPT Assistant*, August 2010, p.8,15; April 2011, p.10-11,15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
12. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion codes 63655 is assigned with removal code 63661 (*CPT Assistant*, April 2011, p.11,15). NCCI edits allow this combination without use of a modifier.

SPINAL CORD STIMULATION
COMMONLY BILLED CODES

Medtronic

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VHA Chief Business Office

CPAC Rates & Charges and Billing

Reasonable Charges are based on amounts that third parties pay for the same services furnished by private-sector health care providers in the same geographic area.

In the past, VA used average cost-based per diem rates for billing insurers. Reasonable charges are calculated for inpatient and outpatient facility charges and for professional or clinician charges for inpatient and outpatient care.

Reasonable Charges Rules, Notices, & Federal Register

- Reasonable Chgs V3.18 Federal Register Notice, 01/01/16 (Outpatient and Professional)(PDF) (https://www.gpo.gov/fdsys/pkg/FR-2015-12-14/pdf/2015-31385.pdf)
- Reasonable Chgs V3.17 Federal Register Notice, 10/01/15 (Inpatient)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2015-09-21/pdf/2015-23585.pdf)
- Reasonable Chgs V3.16 Federal Register Notice, 01/01/15 (Outpatient and Professional)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30309.pdf)
- Reasonable Chgs V3.15 Federal Register Notice, 10/01/14 (Inpatient) (PDF) (http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22906.pdf)
- Reasonable Chgs V3.14 Federal Register Notice, 01/01/14 (Outpatient and Professional)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2013-12-17/pdf/2013-29997.pdf)
- Reasonable Chgs V3.13 Federal Register Notice, 10/01/13 (Inpatient)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2013-09-26/pdf/2013-23508.pdf)
- Reasonable Chgs V3.12 Federal Register Notice, 01/01/13 (Outpatient and Professional)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2012-12-20/pdf/2012-30700.pdf)
- Reasonable Chgs V3.11 Federal Register Notice,10/01/12 (Inpatient)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2012-09-07/pdf/2012-22049.pdf)
- Reasonable Chgs V3.9 Federal Register Notice, 01/01/12 (Outpatient and Professional)(PDF) (http://www.gpo.gov/fdsys/pkg/FR-2011-12-12/pdf/2011-31769.pdf)
- Reasonable Chgs V3.8 Federal Register Notice, 10/01/11 (Inpatient)(PDF) (http://edocket.access.gpo.gov/2011/pdf/2011-24946.pdf)

Reasonable Charges Data Tables

- V3.18 Data Tables (Outpatient and Professional) (http://www.va.gov/CBO/apps/rates/disclaimer/index.cfm?action=rc&ver=43)
- V3.17 Data Tables (Inpatient) (disclaimer/viewFile.asp?ver_ID=42&mode=4&cl=1)
- V3.16 Data Tables (Outpatient and Professional) (disclaimer/index.cfm?action=rc&ver=41)
- V3.15 Data Tables (Inpatient) (disclaimer/viewFile.asp?ver_ID=40&mode=4&cl=1)

- V3.14 Data Tables (Outpatient and Professional) (disclaimer/index.cfm?action=rc&ver=37)
- V3.13 Data Tables (Inpatient) (disclaimer/viewFile.asp?ver_ID=38&mode=4&cl=1)
- V3.12 Data Tables (Outpatient and Professional) (disclaimer/index.cfm?action=rc&ver=36)
- V3.11 Data Tables (Inpatient) (disclaimer/viewFile.asp?ver_ID=34&mode=4&cl=1)
- V3.9 Data Tables (Outpatient and Professional) (disclaimer/index.cfm?action=rc&ver=31)
- V3.8 Data Tables (Inpatient) (disclaimer/viewFile.asp?ver_ID=30&mode=4&cl=1)

Reasonable Charges Data Sources

- Reasonable Charges V3.18 Data Sources (Outpatient and Professional)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p18/datasourcesv3p18.pdf)
- Reasonable Charges V3.17 Data Sources (Inpatient)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p17/datasourcesv3p17.pdf)
- Reasonable Charges V3.16 Data Sources (Outpatient and Professional)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p16/datasourcesv3p16.pdf)
- Reasonable Charges V3.15 Data Sources (Inpatient) (PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p15/datasourcesv3p15.pdf)
- Reasonable Charges V3.14 Data Sources (Outpatient and Professional)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p14/datasourcesv3p14.pdf)
- Reasonable Charges V3.13 Data Sources (Inpatient)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p13/datasourcesv3p13.pdf)
- Reasonable Charges V3.12 Data Sources (Outpatient and Professional)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p12/datasourcesv3p12.pdf)
- Reasonable Charges V3.11 Data Sources (Inpatient)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p11/datasourcesv3p11.pdf)
- Reasonable Charges V3.9 Data Sources (Outpatient and Professional)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p9/datasourcesv3p9.pdf)
- Reasonable Charges V3.8 Data Sources (Inpatient)(PDF) (http://www.va.gov/CBO/apps/rates/rates/v3p8/datasourcesv3p8.pdf)

VA Medical Facility Locations

- VA Medical Facility Locations, V3.18 (Jan16) (http://www.va.gov/CBO/apps/rates/rates/v3p18/facilstv3p18.pdf)
- VA Medical Facility Locations, V3.17 (Oct15) (http://www.va.gov/CBO/apps/rates/rates/v3p17/facilstv3p17.pdf)
- VA Medical Facility Locations, V3.16 (Jan15) (http://www.va.gov/CBO/apps/rates/rates/v3p16/facilstv3p16.pdf)
- VA Medical Facility Locations, V3.15 (Oct14) (http://www.va.gov/CBO/apps/rates/rates/v3p15/facilstv3p15.pdf)
- VA Medical Facility Locations, V3.14 (Jan14) (http://www.va.gov/CBO/apps/rates/rates/v3p14/facilstv3p14.pdf)
- VA Medical Facility Locations, V3.13 (Oct13) (http://www.va.gov/CBO/apps/rates/rates/v3p13/facilstv3p13.pdf)
- VA Medical Facility Locations, V3.12 (Jan13) (http://www.va.gov/CBO/apps/rates/rates/v3p12/facilstv3p12.pdf)
- VA Medical Facility Locations, V3.11 (Oct12) (http://www.va.gov/CBO/apps/rates/rates/v3p11/facilstv3p11.pdf)
- VA Medical Facility Locations, V3.9 (Jan12) (http://www.va.gov/CBO/apps/rates/rates/v3p9/facilstv3p9.pdf)
- VA Medical Facility Locations, V3.8 (Oct11) (http://www.va.gov/CBO/apps/rates/rates/v3p8/facilstv3p8.pdf)